Issue 14: Administrative Reorganization of Developmental Disabilities

Developmental Planning Task Force Final Report

Helena, Montana
December, 1986

Developmental Planning Task Force Members

Tom Crosser, Chairman	Office of Budget and Program Planning
Representative Francis Bardanouve	House of Representatives
Gail Gray	Office of Public Instruction
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January 14, 1987

Tom Crosser
Office of Budget and Program Planning
State Capitol
Helena MT 59601

Representative Cal Winslow
Chairman, Human Services Subcommittee
1240 Crawford Drive
Billings MT 59102

Dear Representative Winslow:

Attached herewith is the final report of the Developmental Planning Task Force's study of "Issue 14: Administrative Reorganization of DD." This report presents our findings and recommendations concerning the proposal contained in the Legislative Fiscal Analyst's Budget Analysis, "Special Session II, (p-86)."

At this time, the Task Force does not recommend restructuring Montana's system of delivering services to citizens with developmental disabilities as proposed by the Legislative Fiscal Analyst. A system change of such magnitude must be approached with caution lest an acknowledged effective system is replaced with one unable to deliver services in the manner which Montanans with developmental disabilities and their families have a right to expect.

Pursuant to your request, the Task Force expended a great deal of energy gathering and analyzing data on which to base a recommendation. The Task Force attempted to compare administrative costs of the existing system with another human service delivery system--community mental health. The more information the Task Force collected about the two systems, the more obvious their essential dissimilarity became. The Task Force ultimately concluded that comparing them directly was not legitimate. It appears to be the classic case of apples and oranges.

The administrative cost data were viewed as inconclusive for several reasons. There was very wide variability in the administrative costs reported by similar provider programs in both community mental health and developmental disabilities systems. Given limited time and resources, no attempt was made to correlate costs with the effectiveness of the two programs. As a result, it was not possible to create a meaningful picture of what the Montana taxpayer actually receives from each system in return for his or her tax dollar.

As part of its primary mission, the Task Force recommended the consolidation of all services for persons with developmental disabilities under the same

administrative authority. (Refer to the recommendations in "Final Report, Developmental Planning Task Force," December, 1986.) The Task Force specifically suggested that an interim legislative committee be established to investigate and evaluate alternatives to achieve that consolidation. If there is further consideration of the Legislative Fiscal Analyst's proposal for restructuring, it should be in the context of the larger issue of reorganization.

In the absence of a dramatic demonstration that restructuring of the DD system is likely to save significant administrative overhead, the Task Force does not recommend restructuring at this time.

Please note that the Task Force's recommendations are, in large part, the result of collection and evaluation of administrative data associated with delivery of services in the mental health and developmental disabilities systems. Because of the extensive data collection, the Task Force relied heavily on the cooperation of numerous individuals in both systems. Task Force members and staff are very grateful to all those who provided that information.

The Task Force appreciated the challenge presented by this study and thanks the subcommittee for providing an opportunity to address this important issue.

Sincerely,

Tom Crosser
Chairman
Developmental Planning Task Force

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PREFACE

This report documents the findings of the Developmental Planning Task Force study of the administrative costs associated with Montana's developmental disabilities service delivery system. The study is in response to legislative concern expressed by the Joint Human Services Subcommittee of the Appropriations-Finance Committee during the Special Session of the legislature, June, 1986.

The Developmental Planning Task Force is a nine-member committee consisting of the Superintendent of the Montana Developmental Center, a representative from the Department of Institutions, the Developmental Disabilities Division Administrator, a delegate from the Office of Public Instruction, the Chairman of the Developmental Disabilities Planning and Advisory Council, a representative from the Montana Association of Independent Disability Service Providers, a delegate from each of the legislative houses, and a representative from the Governor's Budget Office, who also serves as Chairman of the Task Force. It was created in March, 1986, to identify Montanans with developmental disabilities who are unserved or underserved and to determine how best to meet their needs. The Task Force was appointed by the Developmental Disabilities Planning and Advisory Council and is funded jointly by that agency, the Office of Public Instruction and the Departments of Social and Rehabilitation Services and Institutions. The Developmental Disabilities Planning and Advisory Council contracted with an independent consultant to provide staff support for this study.

INTRODUCTION

During the 1986 Special Session, the Human Services Subcommittee of the Appropriations-Finance Committee reviewed a recommendation contained in the Legislative Fiscal Analyst's "Budget Analysis, Special Session II" (page B-86), Issue 14: Administrative Reorganization of Developmental Disabilities. (Refer to Appendix A to review that recommendation in its entirety.)

Although the Fiscal Analyst's recommendation was not adopted by the Subcommittee, it generated considerable interest because it seemed to represent a more cost effective administrative alternative. Aware that the Developmental Planning Task Force was currently conducting a study of developmental disabilities services, the Subcommittee requested that the Task Force include this issue in its study as well. A letter from Cal Winslow, Chairman of the Human Services Subcommittee, to Tom Crosser, Chairman of the Developmental Planning Task Force, made that request official (Appendix B). Chairman Crosser's reply expressed the Task Force's willingness to undertake this project (Appendix C).

Following discussion of the proposed reorganization with Legislative Fiscal Analyst Peter Blouke, the Task Force made the decision to focus on two specific issues:

1. The relative administrative costs of the Developmental Disabilities and Mental Health Divisions at both the service provider and division levels. Since the LFA's analysis cited the community mental health system as a potentially less expensive administrative model, a comparison of the systems seemed appropriate.

2. The relative merits of both systems in maintaining quality assurance. Rural, sparsely populated states were surveyed to obtain relevant information and recommendations.

After a brief discussion of the characteristics of human service delivery systems, the study of these issues will be described.

Delivery System Characteristics

Human service delivery systems are frequently characterized as "regionalized" or "centralized," with reference to their locus of control. Montana's current DD service delivery system has elements of both models. The state Developmental Disabilities Division contracts for services with non-profit providers, enforces quality assurance standards and provides some staff training and support services. Three Area Managers and their staffs are responsible for contract negotiations, contract management, service provider staff training, Individual Habilitation Plan monitoring and quarterly quality assurance reviews.

In other states, a variety of approaches exist. In a strictly centralized system, all contracting and quality assurance functions are reserved for the state. In a regionalized system, the state is divided into a number of service regions and delegation of some decision-making occurs. Counties or combinations of counties may serve as regions; regions may evolve around existing institution facilities or be designated according to population or geographical criteria. A state's central office may share contracting reponsibility with regional staff; it may delegate to regional staff responsibility for contracting with providers or it may contract with non-profit corporations to administer regions and provide services. The State may retain quality assurance responsibilities or pass them to regional administrators. Some regional systems provide all services, some provide selected services and contract for others, some are purely administrative and provide no direct services to clients. Appendix D describes some of the possible configurations.

The Legislative Fiscal Analyst's recommendation is to adopt a regional system wherein the state DD Division would contract with a small number of non-profit corporations to administer regions and provide services, as the Mental Health and Residential Services Division of the Department of Institutions currently

does.

Administrative Costs: Service Providers

The purpose of this part of the study was to compare relative administrative costs of the Developmental Disabilities and Mental Health Divisions. After reviewing contract information from the five Mental Health Regions and the fifty-seven developmental disabilities service providers, it became clear that the contracts would not be an adequate source of data for the following reasons:

1. Current (1987) figures were not always available.
2. There was great variability in the amount of budget detail.
3. There was no way to determine, from job titles, which personnel were administrative, direct care and/or support staff. Therefore, it was not possible to determine the relative costs associated with each.

Methodology

To collect the needed data, Task Force staff conducted a field survey of all community mental health service providers and a selected number of developmental disabilities service providers. The purpose of the survey was to obtain self-reported data on the costs of administrative, direct care and client support activities in each system. To ensure that all those surveyed had a common understanding of the terms, the Task Force sought and located standard definitions of each one. John Ashbaugh, Vice-President of Human Services Research Institute, provided clear, easily-understood definitions of the three classes of activity, which could be applied without modification to both mental health and developmental disabilities service providers and state staff. The following definitions were used:

Direct Care refers to time spent in face-to-face contact with clients.

Client Support refers to time spent in non-face-to-face activity that pertains to an individual client.

Administrative refers to time NOT spent in face-to-face contact with

clients or in a non-face-to-face activity pertaining to an individual client.

Survey Sample

The survey sample included all five regional mental health centers and a stratified random sample of developmental disabilities service providers. The DD sample was stratified to include at least 20% of the providers of each of the following types of service:

Adult residential service providers
Adult day service providers
Child and family service providers
MARF (MT Association of Rehabilitation Facilities)-accredited programs

Twelve DD providers were eliminated from the selection pool because their administrative costs were non-existent or negligible. These included nine which provide only transportation services, one which provides only diagnosis/evaluation services, one which provides only medical case management and one which provides living quarters for a single client. A pool of 45 service providers remained, from which 17 were randomly drawn according to the parameters specified above. (Refer to Appendix E for a complete list of those surveyed.)

Three providers from Area 1, eight from Area II and six from Area III were surveyed. Small, intermediate and large programs were represented, with funding for those providers ranging from $173,723 to $1,498,685. Nearly 40% of the DD providers with significant administrative costs were surveyed.

Survey Instrument

In late September, letters were mailed to the participants--the 17 DD and 5 mental health providers. The letters contained the aforementioned definitions of administrative, direct care and client support activities and requested that the following information be provided (using 1987 budget figures) when the researcher telephoned a week later:

1. The total amount of all salaries (plus benefits) attributable to administrative activities.

2. The total amount of all salaries (plus benefits) attributable to direct care services.

3. The total amount of all salaries (plus benefits) attributable to client support activities.

4. A list of job titles with administrative, direct care and client support responsibilities expressed as percent figures.

5. The total dollar amount of building expenses (rents/leases, utilities, taxes, etc.) attributable to administrative activities.

6. The total dollar amount of building expenses attributable to direct care or client support activities.

7. The total amount of miscellaneous expenses attributable to administrative activities.

8. The total dollar amount of miscellaneous expenses attributable to direct care or client support services.

This information was gathered by telephone and confirmed in a follow-up letter. One DD service provider was unable to respond and one mental health provider elected not to participate. Overall, 94% of DD service providers and 80% of mental health service providers responded to the survey.

Results and Discussion

Direct care and client support costs for personal services, building and miscellaneous expenses were added together, as were administrative costs for the same categories. These figures were subsequently converted to a percent of total budget for comparison. The results are summarized in Table 1 (page 6). Little overall difference between mental health and developmental disabilities providers was found; mental health providers attributed 16.5% of total costs to administrative activities and developmental disabilities providers attributed 18% of costs to administration. There is, however, clearly greater variability among developmental disabilities service providers. The range was from 8% to 30% for developmental disabilities providers and 12% to 22% for mental health providers.

Table 1. Analysis of Provider Costs by Category

Provider	Administrative Costs	Direct Care/Client Support Costs	Percent of Costs Attributable to Administration
DD Provider			
AREA I			
Eastern Montana Industries	$100,628	$593,009	14.5%
Hi-Line Home Programs	45,911	141,894	24.0%
Richland Opportunities	115,495	269,065	30.0%
AREA II			
Blackfeet DD Corporation	49,538	160,845	23.5%
Blaine County Activities	49,959	188,182	21.0%
Easter Seal Adult Training Ctr	99,114	519,873	16.0%
Flathead Industries	243,878	930,854	21.0%
Lincoln Co. Sheltered Workshop	39,900	171,400	19.0%
Little Bitterroot Special Ser.	47,176	207,769	18.5%
Northern Gateway Enterprises	108,670	295,195	27.0%
Region II C & F Services	431,360	1,444,118	23.0%
AREA III			
Big Bear Industries	90,870	468,824	16.0%
Helena Industries	Unavailable at this time		
Ravalli Services	44,074	245,754	15.0%
Reach, Inc.	44,135	502,202	8.0%
Tri-County	120,210	738,192	14.0%
Westmont	132,617	1,230,513	10.0%
MH Provider			
Eastern MT MHC (Miles City)	238,857	1,232,021	16.0%
South Central MHC (Billings)	546,458	1,965,785	22.0%
Mental Health Ser. Inc (Helena)	325,777	1,806,710	16.0%
Golden Triangle MH (Great Falls)	307,394	2,162,674	12.0%
TOTAL Mental Health	$1,418,486	$7,176,190	16.5%
TOTAL Developmental Disabilities	$1,763,535	$8,107,699	18.0%

Administrative Costs: Division Level

Methodology

A letter similar to that sent to service providers was sent to the Administrators of the Developmental Disabilities and Mental Health and Residential Services Divisions in mid-November. The letter requested cost information for all personal, building and miscellaneous expenses using the standard definitions of administrative, direct care and client support. All employees of both divisions were included in the survey, but in the latter case, only employee time spent on community mental health service issues was to be considered. The results were collected in follow-up phone calls.

Results and Discussion

The results are summarized in Table 2.

Table 2. Analysis of Division Costs by Category

Division	Administrative Costs	Direct Care/Client Support Costs	Percent of Costs Attributable to Administration
Developmental Disabilities	$664,139	$504,087	56%
Mental Health	$113,701*	0	100%

*This figure includes only the time spent administering community mental health programs, an average of 45% of the time for each of the four Administrative Officers and 32% average for all seven listed administrative personnel.

Mental Health and Residential Services Division listed seven employees, all with solely administrative duties. The Developmental Disabilities Division listed 31 employees: 12 with direct care, client support and administrative duties, 16 with client support and administrative duties, 2 with solely administrative duties, and one with solely client support duties. Half of all DD employees are stationed in the area offices.

The roles of the state agencies associated with the two systems are different. The Mental Health and Residential Services Division serves a strictly administrative function with all direct client and client support activities delegated, via purchase of service agreements, to local providers. The Developmental Disabilities Division, on the other hand, maintains some direct care and client support functions in addition to its administrative role.

Quality Assurance

Cost effectiveness is not the only characteristic of an exemplary service delivery system. In fact, cost is almost irrelevant if it is not viewed in the context of the services provided. Provision of the highest quality services in the most cost effective way is the primary goal of human service delivery systems. Rather than speculate about the benefits of regionalized and centralized systems, the Task Force elected to conduct a review of other states to collect pertinent information.

All states and the District of Columbia were surveyed by letter concerning the organization of their service delivery system to citizens with developmental disabilities. In addition, each was asked to describe the advantages and disadvantages of that system. Of the 25 respondents, six were dissatisfied with their state's ability to assure quality services. Five of these were highly regionalized systems and one was centralized. Two respondents, both in regionalized systems, cited quality assurance as an advantage to their particular system. No firm conclusions can be drawn from such a small number, but it appears that states with regionalized systems feel that quality assurance is more of a problem than those which have centralized systems.

Two states, California and Wyoming, have systems in which private, non-profit providers are contracted to provide services for regions (similar to the model proposed by the LFA). Although quality assurance was not cited as a problem

in Wyoming, California reported difficulties with evaluation of client programming, quality of life assurances and inconsistent staff training across regions. Appendix D provides further description of the advantages and disadvantages associated with various state systems.

CONCLUSION

The Developmental Planning Task Force concluded that there is no clear monetary advantage to the proposed restructuring at the provider level. There appears to be little difference in the relative administrative costs of mental health and developmental disabilities service providers. Although there appears to be a clear difference in administrative costs of the two systems at the division level, the Task Force is not convinced that the apparent difference warrants restructuring.

A comprehensive comparison of the two systems is extremely difficult. Although both are involved with the provision of human services, they differ considerably in terms of clients, services, personnel and record-keeping requirements. Developmental disabilities service providers offer a wide array of services: 39 group homes in 25 cities and towns for children, adults and senior citizens; 13 child and family service programs; 36 habilitation/day programs in 26 cities and towns; 31 independent living/transitional living programs, plus transportation, evaluation/diagnosis and other services. Employees are frequently paraprofessionals needing considerable training and supervision. The behavioral nature of the client training programs also necessitates an extensive data collection effort.

Mental health service providers, by contrast, offer 11 day treatment programs in 10 cities and 18 transitional living homes in 8 cities, plus other services provided by professional staff. Satellite facilities typically offer walk-in services provided by mental health professionals requiring minimal training and

supervision. In other words, substantial differences in administrative function may well account for the differences in administrative expense.

While the Task Force made no attempt to compare administrative effectiveness between the two systems, frequent reference was made to the general excellence of the DD services. Montana's reputation as a state which provides high quality DD programs was earned under the present administrative model. Montana is one of only thirteen states in which funding for community DD programs equals or exceeds funding for institutional programs. This indicates a philosophical and financial commitment to the concept of provision of services in the least restrictive environment.

Restructuring an apparently effective system seems undesirable without a very compelling reason. In addition, there may be deleterious effects of reorganization, particularly in the areas of start-up costs and potential loss of quality assurance, if one can generalize from the experience of other states.

A final relevant issue is that of local governance and support. Community-based, locally-controlled DD programs have historically benefitted greatly from the expertise, resources and support of their home communities. Although these benefits are not easily quantifiable, there is no question that they exist and that their contribution is substantial. Moreover, parents and other concerned citizens have an emotional investment in maintaining local control of service programs for the community's citizens with developmental disabilities.

RECOMMENDATIONS

The Developmental Planning Task Force recommends:

1. Continuation of Montana's present system of delivering services to citizens with developmental disabilities. The Task Force does NOT recommend restructuring that system as proposed by the Legislative Fiscal Analyst's report.

2. Encouragement of voluntary cost-saving measures such as consolidation of some administrative functions (such as bookkeeping) of small DD service providers in close geographic proximity.

3. Review by the Developmental Disabilities Division of service provider contracts to account for the large discrepancies in the range of administrative costs.

Through February 10, 1986 Department of Social and Rehabilitation Services has committed funds for the following new programs as expanded services for the developmental disabilities waiting list.

Table 27
New Services and Funding for the Developmental Disabilities Waiting List
Through February 1986

Service	Service Slots	Fiscal 1986	Fiscal 1987
Group Homes	119	$236,414	$1,036,434
Vocational Placement	48	25,880	138,208
Day Care	76	186,959	399,125
Specialized Family	24	51,150	204,570
Family Training	39	48,518	89,143
Respite	40	8,160	17,306
Transportation	66	26,355	57,439
Evaluation & Diagnosis	15	3,600	7,561
Total	427	$587,036	$1,949,786

The legislature could require that Department of Social and Rehabilitation Services to not contract for any expanded services during fiscal 1987 except for clients in group homes or specialized family care programs that were begun during fiscal 1986. This would maintain those individuals in state funded residential settings during fiscal 1986 but would eliminate other service expenses beyond the fiscal 1985 level. Elimination of other expanded services for fiscal 1987 would result in a general fund saving of approximately $708,700 during fiscal 1987.

Option A: Eliminate all expanded services for fiscal 1987 except group home or specialized family care for a general fund savings of $708,700.

ISSUE 14: ADMINISTRATIVE REORGANIZATION OF DEVELOPMENTAL DISABILITIES

In response to the mandates of the 1975 legislature to develop community based programs for the developmentally disabled and to deinstitutionalize the population of Boulder River School and Hospital, the Developmental Disabilities Division of

Department of Social and Rehabilitation Services has developed a complex network of over 56 different local corporations with whom they contract for services. Although the number of different corporations may provide some assurance of local control and involvement with developmental disabilities programs, such a system also has a large administrative overhead cost that diverts scarce resources away from direct services. Table 10 presents the fiscal 1985 personal service costs of the program directors and their business offices by region. The table also shows the administrative costs of the regional mental health offices which are $1.2 million less than those for the developmental disabilities programs. As is true with the developmental disabilities programs, there is a very wide diversity of mental health programs operated in almost all counties of the state. However, in the case of the mental health programs, satellite programs are administered through the five regional administrative offices.

Table 28
Comparison of Administrative Personal Service Costs for
Developmental Disabilities and Community Mental Health Programs
Fiscal 1985

Dev. Disabilities Region	Directors' Salaries	Business Office	Total Costs	# Contracts
Region I	$ 198,673	$112,389	$ 311,062	9
Region II	236,889	164,653	401,542	9
Region III	176,321	80,997	257,318	12
Region IV	269,246	238,785	508,031	16
Region V	223,561	144,911	368,472	10
Total	$1,104,690	$741,735	$1,846,425	56
Mental Health Region				
Region I	$ 52,069	$ 57,407	$ 109,476	1
Region II	42,317	107,325	149,642	1
Region III	49,674	79,867	129,541	1
Region IV	50,000	93,000	143,000	1
Region V	54,309	61,737	116,046	1
Total	$248,369	$399,336	$ 647,705	5

The above figures include only the personnel costs and do not identify associated operating expenses. Positions included as directors are director and executive director. Included as business office are business managers, bookkeepers, payroll clerks, vice president of finance, comptrollers, and accountants.

In addition to the community based administrative overhead that is associated with a large number of contract agencies, the size of the developmental disabilities division staff of Department of Social and Rehabilitation Services is also a direct result of having to interact with the diversity of management policies associated with as many as 56 separate corporations. Many of the functions that are currently performed by the division, such as data collection and analysis, program evaluation, contract negotiations, and contract budgeting and monitoring could be delegated to a regional office. It is reasonable to assume that considerable administrative efficiencies and potential developmental disabilities division staff reductions could be realized if the number of contracts were reduced from 56 to 5. The following table compares the staff and total budgetary responsibility of the Developmental Disabilities of Department of Social and Rehabilitation Services and the Mental Health Division in the Department of Institutions. Although the Developmental Disabilities Division is only responsible for administration of the developmental disabilities community programs, the Mental Health Division supervises seven major institutional programs as well as the community mental health programs.

Table 29
Comparison of DD and MH Division Staff and Budgetary Responsibility
Fiscal 1984

Program	Total Staff	Staff Cost	Total Budgetary Responsibility
Dev. Disability	30.25	$785,175	$14,227,902
Mental Health	5.00	167,778	44,037,393

Essentially both the developmental disabilities system and the mental health system must provide for the same administrative functions of budgeting, quality control, crisis management, and policy development. However, because the developmental disabilities division must deal separately with 56 contract organizations, the central office staff requirements are much greater than for those of the mental health division and there is the potential for unnecessary administrative duplication. For example, budgeting and routine business office operations are necessary in both systems. However, as shown in table 10, because the mental health system is regionalized and the business office functions are consolidated in a regional mental health office, the business office costs for the mental health system are considerably less than the business office costs of the developmental disabilities system. Additionally, because the Mental Health Division only needs to process the budgets and contract negotiations for five corporations instead of the 56 corporations with which the Developmental Disabilities Division must interact, the central office mental health manpower needs are appreciably less.

The legislature could require Department of Social and Rehabilitation Services to adopt a regionalized administrative structure for the developmental disabilities community based programs. Such a reorganization would require the consolidation of all developmental disabilities programs within each region under a single administration with one administrative director and a centralized business office. Although the current mental health system might serve as a model, other alternatives could be considered and the final structure should incorporate input from both the department and provider groups. A proposal from the department should be available at the beginning of the regular 1987 legislative session. Based on the experience of the Mental Health Programs, the potential savings would be approximately $1.2 million in general funds per fiscal year.

Option A: Require that a regionalization plan be submitted to the 1987 legislature with a goal of effecting savings in program and administrative costs.

June 30, 1986

Mr. Tom Crosser
Office of Budget and Program Planning
Room 237
State Capitol
Helena, MT 59620

Dear Mr. Crosser:

During the recent legislative committee hearings on the budget for the Developmental Disabilities division of the department of Social and Rehabilitation Services, there was considerable discussion of the growth and efficiency of the state's current service delivery system for developmental disabilities services. Specifically, the Committee reviewed ~~the recommendation contained in the Legislative Fiscal Analyst "Budget Analysis, Special Session III" page B-86 Issue 14: Administrative Reorganization of Developmental Disabilities~~.

Although the Committee did not specifically adopt the recommendations contained in the Fiscal Analyst's report, the Committee was interested in pursuing the issue of increased efficiency for the developmental disabilities program because public funding for all services is becoming increasingly scarce. Testimony was presented by Mr. Dave Lewis that the Governor's Office was currently conducting a study of the developmental disabilities program and that this task force, chaired by Mr. Tom Crosser, included representation from a broad spectrum of persons involved in the program. Rather than duplicate the efforts of this task force, it was the unanimous vote of the Committee that a letter be sent to Mr. Crosser requesting that they include in their study an analysis of the issues raised by the Legislative Fiscal Analyst. Further, it was the desire of the Committee that if possible a report be available to the next regular session of the legislature with specific recommendations for change if that is the conclusion of your task force.

~~As Chairman of the Human Services Subcommittee, I am therefore requesting that your task force, Phase II Developmental Planning Task Force, include in their deliberations the issues outlined above~~. I would appreciate notification of your decision regarding inclusion of the Committee's interests in your study and a tentative time frame of the task force study.

Sincerely,

Representative Cal Winslow
Chairman Human Services Committee

PBSS:kj:tc

Appendix C

August 20, 1986

Representative Cal Winslow
1240 Crawford Drive
Billings, MT 59102

Dear Representative Winslow:

I apologize for the delay in responding to your request made during the Special Session in June concerning the DD service delivery system. Because of the time commitment, I felt that all members of the Phase II DD Task Force should be given an opportunity to comment on your request.

All Task Force members responding have indicated support for your request. Efficiency is the only way we can increase service care at this point in time. I have asked Peter Blouke to attend our next meeting and expand on the proposal presented in the LFA writeup. In addition, our staff person has been authorized by the Planning Council to hire an additional researcher to help with the study.

Due to the timing, we probably will not be able to have a recommendation until late fall. This will probably prevent the inclusion of any of our recommendations in the official budget of the Governor or the LFA analysis of that budget.

Hopefully, we will be able to provide a report to your committee prior to the regular session. This report will include not only the issue presented in your request, but also the primary objective of the Task Force. This objective is to quantify the extent of unserved and underserved DD populations and try to design a service delivery system that addresses these unmet needs.

I look forward to working with you, your staff and your Committee.

Sincerely,

Thomas L. Crosser

Thomas L. Crosser, Chairman
Phase II Task Force

A Summary of Advantages and Disadvantages Associated with DD Service Delivery Systems in a Variety of States

State	Agency: Provider Contract Negotiation	Agency: Provider Contract Monitoring	Disadvantages	Advantages
Alabama	Five Service Regions	Service Regions		
Arkansas	State Office	State Office		
California	21 private, non-profit Regional Centers	Regional Centers	Inconsistent quality of care and staff training standards; Inability to staff less populous regions adequately	Services are based on local needs
Connecticut	State Office	State Office	Services limited to certain categorical populations; Limited resources	More people have access to system; Disabled people more rapidly integrated into community
Delaware	State Office	State Office		
District of Columbia	District Office	District Office	Scant resources for non-MR people with DD	
Florida	11 Administrative Districts	Administrative Districts		
Indiana	State Office	35 Service Regions	Poor participation; Personality Conflicts; Territoriality	Community participation in implementing & coordinating services; Consolidation of providers
Iowa	99 County Programs	Counties	State lacks authority to plan for, develop or track county services	
Kentucky	17 MH/MR Boards	State Office/Boards	Lack of departmental and Board accountability	Avoids fragmentation of services, service gaps or duplication; Assures provision of service

State Summary (cont.)

State	Agency: Provider Contract Negotiation	Agency: Provider Contract Monitoring	Disadvantages	Advantages
Louisiana	Eight Regions	Regions	Start-up Costs; Regional performance tied to each director's philosophy; Slow community growth	Improved service delivery for rural clients
Maine	Six Regions	State Office		
Maryland	State Office/ Four Regions	State Office	Duties/responsibilities of regional directors not clear; inadequate regional staff; lack of regional control over community funding; disparity in authority and practices of directors	Savings in transportation cost
Massachusetts	State Office	State Office	Waiting list of 3000; No formal quality assurance system; Lack of inter-agency coordination	
Minnesota	87 County-administered Programs	State Office		Maximizes local knowledge of resources, feeling of local ownership; Statewide criteria for services
Mississippi	15 Regional Commissions	Regional Commissions		
Missouri	State Office (for 11 regional centers)	State Office	Lack of appropriate community placement facilities; additional case management and assessment staff needed	
New Hampshire	10 Service Areas	Service Areas		
New Jersey	State Office (for regional centers)	State Office		Allows equitable service distribution & achievement of goa

State Summary (cont.)

State	Agency: Provider Contract Negotiation	Agency: Provider Contract Monitoring	Disadvantages	Advantages
New York	20 District Offices in 3 Areas	Community Service Boards		
Oregon	26 County MH programs/State Office	State Office	Inequities across programs; difficulty of MH programs in meeting accountability requirements for MH/DD and Drug/Alcohol; Lack of Training in MR/DD	Local control and responsiveness
Pennsylvania	43 County MH/MR Programs/State Office	State Office		Assures equitable provision of services
South Carolina	State Office	30 County MR Boards	Conflict between County Boards and Provider Administration	Full use of community resources
Virginia	State Office/ 40 community service boards	State Office	No community offers a full range of services to meet needs of all clients	Community is responsible for individual client without regard for location of service delivery

Appendix D. A Summary of Advantages and Disadvantages Associated with DD Service Delivery Systems in Rural, Sparsely Populated States.

State	Agency: Provider Contract Negotiation	Agency: Provider Contract Monitoring	Disadvantages	Advantages
Alaska	State Office	State Office		
Arizona	Six state-staffed service districts	Service districts		Flexibility in designing and planning services; Community acceptance
Colorado	State Office/ 22 community-centered boards	State Office	Inadequate monitoring and provision of service in regional centers	
Idaho	Seven Health and Welfare Regions	Regions		
Nebraska	Six Central Administrative Offices	Area Offices	No governmental entity responsible for assuring service delivery; little client movement through system	Maximum local control and responsiveness
Nevada	State Office/ Three Regions	State Office		
New Mexico	State Office	State Office		
North Dakota	State Office	State Office		
South Dakota	State Office	State Office		
Utah	State Office	State Office		
Wyoming	State Office contracts with nine private non-profit adult regional centers and fourteen preschool regions which provide services		Must achieve balance between enforcing state standards and allowing regional autonomy	Economical; Fewer State staff, Greater Accountability

NOTE: All disadvantages and advantages were cited by the state; in other words, they were self-reported.